FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040071

Facility Name: MONROE PAVILION HEALTH/T CTR

Address: 1400 WEST MONROE (Number) CHICAGO (City) 60607 (Zip Code)

County: COOK

Telephone Number: (312) 666-4090 **Fax #** (312) 421-0134

IDPA ID Number: 363961690001

Date of Initial License for Current Owners: 07/01/94

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) RICHARD S. SGARLATA, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	136	Intermediate (ICF)	136	49,640	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	136	TOTALS	136	49,640	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	45,845	217	1,783	47,845	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	45,845	217	1,783	47,845	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.38%

D. How many bed-hold days during this year were paid by Public Aid?
456 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 7/1/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 7/1/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	160,804	17,301	8,260	186,365		186,365	15	186,380			1
2	Food Purchase		196,979		196,979	(10,439)	186,540	(778)	185,762			2
3	Housekeeping	159,749	31,587		191,336		191,336		191,336			3
4	Laundry		1,194		1,194		1,194		1,194			4
5	Heat and Other Utilities			113,930	113,930		113,930	480	114,410			5
6	Maintenance	56,060	10,565	50,241	116,866		116,866	(426)	116,440			6
7	Other (specify):*							19	19			7
8	**TOTAL General Services**	376,613	257,626	172,431	806,670	(10,439)	796,231	(690)	795,541			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	1,080,869	53,204	6,882	1,140,955		1,140,955	(36,491)	1,104,464			10
10a	Therapy											10a
11	Activities	92,915	2,821	2,798	98,534		98,534		98,534			11
12	Social Services			4,244	4,244		4,244		4,244			12
13	Nurse Aide Training											13
14	Program Transportation			125	125		125	222	347			14
15	Other (specify):*							44	44			15
16	**TOTAL Health Care and Programs**	1,173,784	56,025	23,049	1,252,858		1,252,858	(36,225)	1,216,633			16
	C. General Administration											
17	Administrative	95,897		291,538	387,435		387,435	(209,143)	178,292			17
18	Directors Fees											18
19	Professional Services			48,384	48,384	(2,754)	45,630	1,273	46,903			19
20	Dues, Fees, Subscriptions & Promotions			29,236	29,236		29,236	(15,131)	14,105			20
21	Clerical & General Office Expenses	51,087	17,338	53,796	122,221		122,221	73,550	195,771			21
22	Employee Benefits & Payroll Taxes			269,917	269,917	10,439	280,356		280,356			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,343	1,343		1,343	106	1,449			24
25	Other Admin. Staff Transportation			372	372		372	206	578			25
26	Insurance-Prop.Liab.Malpractice			49,005	49,005		49,005	357	49,362			26
27	Other (specify):*							18,890	18,890			27
28	**TOTAL General Administration**	146,984	17,338	743,591	907,913	7,685	915,598	(129,892)	785,706			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,697,381	330,989	939,071	2,967,441	(2,754)	2,964,687	(166,807)	2,797,880			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR #0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			48,643	48,643		48,643	74,637	123,280			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			22,804	22,804		22,804	461,073	483,877			32
33	Real Estate Taxes			73,643	73,643	2,754	76,397		76,397			33
34	Rent-Facility & Grounds			765,702	765,702		765,702	(758,753)	6,949			34
35	Rent-Equipment & Vehicles			3,590	3,590		3,590	5,237	8,827			35
36	Other (specify):*			5,364	5,364		5,364	(5,364)				36
37	TOTAL Ownership			919,746	919,746	2,754	922,500	(223,170)	699,330			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers							25	25			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			74,460	74,460		74,460		74,460			42
43	Other (specify):*	7,989			7,989		7,989	(7,989)				43
44	TOTAL Special Cost Centers	7,989		74,460	82,449		82,449	(7,964)	74,485			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,705,370	330,989	1,933,277	3,969,636		3,969,636	(397,941)	3,571,695			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	71,529	30		9
10	Interest and Other Investment Income	(179)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(9)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(171)	21		18
19	Entertainment				19
20	Contributions	(16,025)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,959)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(421)	20		28
29	Other-Attach Schedule	(81,573)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (28,808)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(369,133)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (369,133)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (397,941)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

MONROE PAVILION HEALTH/T CTR

ID# 0040071

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Political Contributions - ICLTC	$ (997)	20	1
2	Bank Charges	(4,322)	21	2
3	Prior Period Seminar Expense	(783)	24	3
4	Amortization of Goodwill	(5,364)	36	4
5	Bad Debts	(22,500)	21	5
6	Pharmacy Veterans	(21,282)	10	6
7	Veteran's Medical Expenses	(4,320)	10	7
8	Marketing Salary	(7,989)	43	8
9	Patient Needs	(6,649)	10	9
10	Patient Clothing	(1,400)	10	10
11	Misc. Income - Food	(769)	2	11
12	Misc. Income - Telephone	(264)	21	12
13	Misc. Income - Copies	(100)	21	13
14	Prior Period Expense - Pharmacy	(3,376)	10	14
15	Capitalized Repairs & Maint.	(1,458)	6	15
16				16
17				17
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STATE OF ILLINOIS

Summary A

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			15									15	1
2	Food Purchase	(778)											(778)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			480									480	5
6	Maintenance	(1,458)		1,032									(426)	6
7	Other (specify):*			19									19	7
8	**TOTAL General Services**	(2,236)		1,546									(690)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(37,027)		536									(36,491)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation			222									222	14
15	Other (specify):*			44									44	15
16	**TOTAL Health Care and Programs**	(37,027)		802									(36,225)	16
	C. General Administration													
17	Administrative			1,007	(199,615)	(10,535)							(209,143)	17
18	Directors Fees													18
19	Professional Services			801		472							1,273	19
20	Fees, Subscriptions & Promotions	(19,402)		448		3,823							(15,131)	20
21	Clerical & General Office Expenses	(27,357)		99,715		1,192							73,550	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(783)		875		14							106	24
25	Other Admin. Staff Transportation			206									206	25
26	Insurance-Prop.Liab.Malpractice			357									357	26
27	Other (specify):*			14,697	1,832	2,361							18,890	27
28	**TOTAL General Administration**	(47,542)		118,106	(197,783)	(2,673)							(129,892)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(86,805)		120,454	(197,783)	(2,673)							(166,807)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	71,529		3,108									74,637	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(179)	463,051	(1,799)									461,073	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(765,702)	6,949									(758,753)	34
35	Rent-Equipment & Vehicles			5,237									5,237	35
36	Other (specify):*	(5,364)											(5,364)	36
37	**TOTAL Ownership**	65,986	(302,651)	13,495									(223,170)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers			25									25	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(7,989)											(7,989)	43
44	**TOTAL Special Cost Centers**	(7,989)		25									(7,964)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(28,808)	(302,651)	133,974	(197,783)	(2,673)							(397,941)	45

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Monroe Associates	Chicago	Bldg Company

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent Income	$ 765,702	Monroe Associates	100.00%	$	$ (765,702)	1
2	V	32	Interest Expense		Monroe Associates	100.00%	463,051	463,051	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 765,702			$ 463,051	$ * (302,651)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	NUCARE SERVICES CORP.	100.00%	$ 15	$ 15	15
16	V	5	UTILITIES		NUCARE SERVICES CORP.	100.00%	480	480	16
17	V	6	REPAIRS AND MAINT.		NUCARE SERVICES CORP.	100.00%	1,032	1,032	17
18	V	7	EMPLOYEE BEN. GEN. SERV.		NUCARE SERVICES CORP.	100.00%	19	19	18
19	V	10	NURSING ADMIN. COMP.		NUCARE SERVICES CORP.	100.00%	536	536	19
20	V	14	PROGRAM TRANSPORTATION		NUCARE SERVICES CORP.	100.00%	222	222	20
21	V	15	HEALTHCARE BENEFITS		NUCARE SERVICES CORP.	100.00%	44	44	21
22	V	17	ADMINISTRATIVE - NON-OWNER		NUCARE SERVICES CORP.	100.00%	1,007	1,007	22
23	V	19	PROFESSIONAL FEES		NUCARE SERVICES CORP.	100.00%	801	801	23
24	V	20	FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.	100.00%	448	448	24
25	V	21	CLERICAL & GENERAL		NUCARE SERVICES CORP.	100.00%	99,715	99,715	25
26	V	24	SEMINARS AND EDUCATION		NUCARE SERVICES CORP.	100.00%	875	875	26
27	V	25	ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.	100.00%	206	206	27
28	V	26	INSURANCE		NUCARE SERVICES CORP.	100.00%	357	357	28
29	V	27	EMPLOYEE BEN. GEN. ADMIN.		NUCARE SERVICES CORP.	100.00%	14,697	14,697	29
30	V	30	DEPRECIATION		NUCARE SERVICES CORP.	100.00%	3,108	3,108	30
31	V	32	INTEREST EXPENSE		NUCARE SERVICES CORP.	100.00%	(1,799)	(1,799)	31
32	V	34	BUILDING RENT		NUCARE SERVICES CORP.	100.00%	6,949	6,949	32
33	V	35	EQUIPMENT RENTAL		NUCARE SERVICES CORP.	100.00%	5,237	5,237	33
34	V	39	ANCILLARY		NUCARE SERVICES CORP.	100.00%	25	25	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 133,974	$ * 133,974	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMIN. - R. HARTMAN	$	NUCARE SERVICES CORP.	100.00%	$ 53,151	$ 53,151	15
16	V	17	ADMIN. - B. CARR		NUCARE SERVICES CORP.	100.00%	13,326	13,326	16
17	V	17	ADMIN. - D. HARTMAN		NUCARE SERVICES CORP.	100.00%	1,446	1,446	17
18	V	17	ADMIN. - E. DICKMAN		NUCARE SERVICES CORP.	100.00%			18
19	V	27	EMP. BEN. - R. HARTMAN		NUCARE SERVICES CORP.	100.00%	1,147	1,147	19
20	V	27	EMP. BEN. - B. CARR		NUCARE SERVICES CORP.	100.00%	572	572	20
21	V	27	EMP. BEN. - D. HARTMAN		NUCARE SERVICES CORP.	100.00%	113	113	21
22	V	27	EMP. BEN. - E. DICKMAN		NUCARE SERVICES CORP.	100.00%			22
23	V								23
24	V								24
25	V	17	MANAGEMENT FEES	267,538	NUCARE SERVICES CORP.	100.00%		(267,538)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 267,538			$ 69,755	$ * (197,783)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$	CAREPATH HEALTH NETWORK	100.00%	$ 13,465	$ 13,465	15
16	V	19	PROFESSIONAL FEES		CAREPATH HEALTH NETWORK	100.00%	472	472	16
17	V	20	FEES, SUBSCRIPTIONS		CAREPATH HEALTH NETWORK	100.00%	3,823	3,823	17
18	V	21	CLERICAL AND GENERAL		CAREPATH HEALTH NETWORK	100.00%	1,192	1,192	18
19	V	24	SEMINARS		CAREPATH HEALTH NETWORK	100.00%	14	14	19
20	V	27	GEN ADMIN.- EMP. BEN.		CAREPATH HEALTH NETWORK	100.00%	2,361	2,361	20
21	V				CAREPATH HEALTH NETWORK	100.00%			21
22	V				CAREPATH HEALTH NETWORK	100.00%			22
23	V				CAREPATH HEALTH NETWORK	100.00%			23
24	V	17	MANAGEMENT FEES	24,000	CAREPATH HEALTH NETWORK	100.00%		(24,000)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 24,000			$ 21,327	$ * (2,673)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Workers Comp Insurance	$ 21,993	Diamond Insurance	40.00%	$ 21,993	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 21,993			$ 21,993	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Robert Hartman	Owner	Administration	60.75%	See Attached	2.7	4.15%	All. Salary	$ 53,151	17-7	1
2	Barry Carr	Owner	Administration	4.75%	See Attached	3	6.67%	All. Salary	13,326	17-7	2
3	David Hartman	Relative	Administration	0	See Attached	.4	0.89%	All. Salary	1,446	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 67,923		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NUCARE SERVICES CORP.
Street Address: 6677 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 933-2600
Fax Number: (847) 933-2601

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	AVAIL. CENSUS DAYS	672,540	8	$ 205	$	49,640	$ 15	1
2	5	UTILITIES	AVAIL. CENSUS DAYS	672,540	8	6,508		49,640	480	2
3	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	672,540	8	13,988	1,054	49,640	1,032	3
4	7	EMPLOYEE BEN. GEN. SERV.	AVAIL. CENSUS DAYS	672,540	8	258		49,640	19	4
5	10	NURSING ADMIN. COMP.	AVAIL. CENSUS DAYS	672,540	8	7,261	2,431	49,640	536	5
6	14	PROGRAM TRANSPORTATION	AVAIL. CENSUS DAYS	672,540	8	3,009		49,640	222	6
7	15	HEALTHCARE BENEFITS	AVAIL. CENSUS DAYS	672,540	8	595		49,640	44	7
8	17	ADMINISTRATIVE - NON-OWN	AVAIL. CENSUS DAYS	672,540	8	13,648	8,000	49,640	1,007	8
9	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	672,540	8	10,851		49,640	801	9
10	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	672,540	8	6,065		49,640	448	10
11	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS	672,540	8	1,350,975	1,102,702	49,640	99,715	11
12	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	672,540	8	11,855		49,640	875	12
13	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	672,540	8	2,788		49,640	206	13
14	26	INSURANCE	AVAIL. CENSUS DAYS	672,540	8	4,831		49,640	357	14
15	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS	672,540	8	199,124		49,640	14,697	15
16	30	DEPRECIATION	AVAIL. CENSUS DAYS	672,540	8	42,107		49,640	3,108	16
17	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	672,540	8	(24,377)		49,640	(1,799)	17
18	34	BUILDING RENT	AVAIL. CENSUS DAYS	672,540	8	94,150		49,640	6,949	18
19	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	672,540	8	70,953		49,640	5,237	19
20	39	ANCILLARY	AVAIL. CENSUS DAYS	672,540	8	335	269	49,640	25	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,815,129	$ 1,114,456		$ 133,974	25

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NUCARE SERVICES CORP.
Street Address: 6677 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 933-2600
Fax Number: (847) 933-2601

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMIN. - R. HARTMAN	AVG. HOURS WORKED	36.52	8	720,115	720,000	2.70	53,151	1
2	17	ADMIN. - B. CARR	AVG. HOURS WORKED	40.00	8	177,679	175,000	3.00	13,326	2
3	17	ADMIN. - D. HARTMAN	AVG. HOURS WORKED	5.00	8	18,073	17,000	0.40	1,446	3
4	17	ADMIN. - E. DICKMAN	AVG. HOURS WORKED	35.00	1	20,728	19,166			4
5	27	EMP. BEN. - R. HARTMAN	AVG. HOURS WORKED	36.52	8	15,535		2.70	1,147	5
6	27	EMP. BEN. - B. CARR	AVG. HOURS WORKED	40.00	8	7,632		3.00	572	6
7	27	EMP. BEN. - D. HARTMAN	AVG. HOURS WORKED	5.00	8	1,411		0.40	113	7
8	27	EMP. BEN. - E. DICKMAN	AVG. HOURS WORKED	35.00	1	1,576				8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 962,749	$ 931,166		$ 69,755	25

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPATH HEALTH NETWORK
Street Address: 6633 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (888) 707-6700
Fax Number: (847) 679-2150

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	CARE PATH FEES	629,760	13	$ 353,316	$ 353,316	24,000	$ 13,465	1
2	19	PROFESSIONAL FEES	CARE PATH FEES	629,760	13	12,396		24,000	472	2
3	20	FEES, SUBSCRIPTIONS	CARE PATH FEES	629,760	13	100,317		24,000	3,823	3
4	21	CLERICAL AND GENERAL	CARE PATH FEES	629,760	13	31,275		24,000	1,192	4
5	24	SEMINARS	CARE PATH FEES	629,760	13	366		24,000	14	5
6	27	GEN ADMIN.- EMP. BEN.	CARE PATH FEES	629,760	13	61,960		24,000	2,361	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 559,630	$ 353,316		$ 21,327	25

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Diamond Insurance
Street Address: 40 Skokie Blvd., Suite 105
City / State / Zip Code: Northbrook, IL 60062
Phone Number: (847) 559-1002
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Diamond Insurance	Direct Allocation			$	$		$ 21,993	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 21,993	25

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	LaSalle Bank		X	Working Capital	Interest Only						22,804	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 22,804	9
	B. Non-Facility Related*											
10	See Supplemental Schedule							500,000			461,073	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$ 500,000			$ 461,073	14
15	TOTALS (line 9+line14)						$	$ 500,000			$ 483,877	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Interest Income		X				$	$			$ (179)	1
2	Shareholder Loan	X						500,000				2
3	Alloc. from NuCare	X									(1,799)	3
4	Alloc. from Monroe Assoc.	X									463,051	4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$ 500,000			$ 461,073	21

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	77,441	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	73,699	2
3. Under or (over) accrual (line 2 minus line 1).	$	(3,742)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	77,384	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	2,754	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	76,396	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	72,004	8
	1997	72,956	9
	1998	74,251	10
	1999	73,504	11
	2000	73,699	12

2001 R/E Tax Accrual: $73,699 X 1.05 = 77,384 less 3/02 installment payment of $36,850

Line 2 taxes

2000 R/E Tax Accrual adjusted for escrow amount.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MONROE PAVILION HEALTH/T CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0040071

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	17-17-102-043-000	Long-Term Care Property	$ 73,699.32	$ 73,699.32
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 73,699.32	$ 73,699.32

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 45,004 B. General Construction Type: Exterior Brick Frame Reinforced Concrete Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 80,453
2. Number of Years Over Which it is Being Amortized: 15 Years
3. Current Period Amortization: 5,364
4. Dates Incurred: 1994

Nature of Costs: Goodwill: Accrued sick and vacation days
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	39,159	1982	$ 30,464	1
2					2
3	TOTALS	39,159		$ 30,464	3

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1994	13,951		20	358	358	2,610	9
10	Various			1995	13,124		20	657	657	4,374	10
11	Various			1996	19,194		20	961	961	4,983	11
12	Various			1997	32,365		20	1,619	(1,619)	7,314	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		2,147,596	92		83,663	83,571	1,644,484	68
69	Financial Statement Depreciation			48,639			(48,639)		69
70	TOTAL (lines 4 thru 69)		$ 2,226,230	$ 48,731		$ 87,258	$ 35,289	$ 1,663,765	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,226,230	$ 48,731		$ 87,258	$ 38,527	$ 1,663,765	1
2	FIRE DAMPERS REPAIR	1998	663		20	33	33	129	2
3	LIFE SAFETY CODE REP	1998	1,143		20	57	57	219	3
4	FIRE & SMOKE DAMPER	1998	1,481		20	74	74	278	4
5	LIFE SAFETY REPAIR	1998	453		20	23	23	86	5
6	CABE INSTALLATION	1998	3,484		20	174	174	653	6
7	SPRINKLER REPAIR	1998	1,620		20	81	81	297	7
8	WALLPAPERING ADMIN O	1998	1,500		20	75	75	263	8
9	CAST IRON SECTIONAL	1998	8,648		20	432	432	1,440	9
10	CARPETING	1998	2,922		20	146	146	511	10
11	RESULT HEAT EXCHANGE	1998	1,498		20	75	75	244	11
12	CEILING RADIATION DA	1998	3,050		20	153	153	497	12
13	PARTITION FOR WASHRO	1998	5,818		20	291	291	946	13
14	TWO FIRE DOORS	1998	690		20	35	35	111	14
15	FIRE DAMPERS INSTALL	1998	1,927		20	96	96	296	15
16	ELEVATOR MODERATION	1998	1,730		20	87	87	268	16
17	RADIATOR REPAIR	1998	2,762		20	138	138	552	17
18	AUDIO SYSTEM REPAIR	1998	818		20	41	41	161	18
19	SPRINKLER SYSTEM REP	1998	827		20	41	41	133	19
20	WALLPAPER	1998	1,275		20	64	64	229	20
21	TEST STATION	1998	519		20	26	26	104	21
22	FIRE ALARM REPAIR	1998	656		20	33	33	129	22
23	CEILING TILE	1998	682		20	34	34	113	23
24	CEILING TILE	1998	682		20	34	34	113	24
25	CEILING TILE	1998	682		20	34	34	108	25
26	CEILING TILE	1998	705		20	35	35	111	26
27	CEILING TILE	1998	682		20	34	34	105	27
28	SPRINKLE SYSTEM ELEC	1998	3,962		20	198	198	434	28
29	LIFE SAFETY REPAIR	1999	685		20	34	34	102	29
30	ELEVATOR COIL REPAIR	1999	981		20	49	49	147	30
31	FIRE DOOR PREP	1999	584		20	29	29	85	31
32	FLOOR TILE	1999	713		20	36	36	108	32
33	REPAIR WATER PUMP&FA	1999	1,178		20	59	59	172	33
34	TOTAL (lines 1 thru 33)		$ 2,281,250	$ 48,731		$ 90,009	$ 41,278	$ 1,672,909	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,281,250	$ 48,731		$ 90,009	$ 41,278	$ 1,672,909	1
2	REPAIR FAST&WEST ELE	1999	6,550		20	328	328	929	2
3	WORK ON FIRE DAMPERS	1999	4,104		20	205	205	615	3
4	LIFE SAFETY REPAIRS	1999	1,664		20	83	83	242	4
5	DIESEL FUEL TANK	1999	2,344		20	117	117	322	5
6	WALLPAPER	1999	8,450		20	423	423	1,199	6
7	WALLPAPER	1999	2,412		20	121	121	303	7
8	NURSES CALL SYSTEM	1999	1,808		20	90	90	270	8
9	REPAIR OUTLETS&PHONE	1999	990		20	50	50	150	9
10	FURNISH AND INSTALL	1999	487		20	24	24	72	10
11	FURNISH AND INSTALL	1999	426		20	21	21	63	11
12	FURNISH AND INSTALL	1999	1,116		20	56	56	168	12
13	BASE COVE	1999	320		20	16	16	39	13
14	WINDOW TREATMENTS	1999	5,101		20	255	255	595	14
15	FLOOR TILE	1999	687		20	34	34	82	15
16	CRASH RAIL & CAPS	1999	630		20	32	32	83	16
17	TASSOGLASS WALLCOVER	1999	1,981		20	99	99	256	17
18	WALLPAPER BORDER	1999	168		20	8	8	21	18
19	WALLPAPER BORDER	1999	167		20	8	8	21	19
20	COVE BASES	1999	310		20	16	16	41	20
21	ELEVATOR RELAYS	1999	2,303		20	115	115	240	21
22	RADIATOR REPAIR	1999	713		20	36	36	87	22
23	DOOR ALARM SYSTEM	1999	1,100		20	55	55	165	23
24	SPRINKLE SYSTEM	1999	602		20	30	30	90	24
25	WALL MOUNT PULL STAT	1999	555		20	28	28	75	25
26	WALL MOUNT FIRE HORN	1999	584		20	29	29	77	26
27	TAMPER SWITCHES ON P	1999	716		20	36	36	96	27
28	FRONT DOOR RELEASE	1999	899		20	45	45	120	28
29	PA & TELEPHONE SERV.	1999	399		20	20	20	53	29
30	TELEPHONE LINES	1999	436		20	22	22	59	30
31	CCTV SYSTEM	1999	813		20	41	41	85	31
32	ELEVATOR BEARINGS	1999	904		20	45	45	128	32
33	ELEVATOR RELAYS	1999	785		20	39	39	88	33
34	TOTAL (lines 1 thru 33)		$ 2,331,774	$ 48,731		$ 92,536	$ 43,805	$ 1,679,743	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,331,774	$ 48,731		$ 92,536	$ 43,805	$ 1,679,743	1
2	TELEPHONE SYSTEM	1999	616		20	31	31	67	2
3	TELEPHONE SYSTEM	1999	581		20	29	29	63	3
4	PA SYSTEM AND CCTV	1999	776		20	39	39	91	4
5	PHONE SYSTEM & CCTV	1999	581		20	29	29	68	5
6	BASE COVE	1999	6,330		20	317	317	705	6
7	600 GALLON TANK	2000	26,300		20	1,315	1,315	2,520	7
8	CONTROLLER WIRES	2000	2,324		20	116	116	222	8
9	3 RELAY CONTACTS	2000	879		20	44	44	84	9
10	REPAIR CONTACT	2000	572		20	29	29	58	10
11	INSTL EXTERIOR LIGHT	2000	648		20	32	32	56	11
12	SERVICE CCTV SYSTEM	2000	1,295		20	65	65	114	12
13	CCTV SYS & NURSE SYS	2000	961		20	48	48	84	13
14	INSTALL 2 WINDOWS	2000	670		20	34	34	57	14
15	REWIRE CONTACT	2000	1,402		20	70	70	123	15
16	REPAIR ELEVATOR	2000	2,770		20	139	139	232	16
17	FURNISH NEW PACKING	2000	512		20	26	26	43	17
18	REPLACE WIRES	2000	555		20	28	28	56	18
19	REPLACED RECLAIMER	2000	1,453		20	73	73	116	19
20	DOOR TRACK ROLLERS	2000	754		20	38	38	57	20
21	REPL LEVEL SWITCH	2000	1,515		20	76	76	114	21
22	FURN&INST GLASS & LA	2000	1,054		20	53	53	80	22
23	NEW TUBING FOR RETUR	2000	1,875		20	94	94	125	23
24	200 GALLON TANK	2000	3,045		20	152	152	203	24
25	CEILING TILE	2000	740		20	37	37	46	25
26	PUMPED 600 GAL WATER	2000	1,530		20	77	77	122	26
27	FIRE ALARM PLANS	2000	2,400		20	120	120	130	27
28	NURSE CALL SYSTEM	2000	502		20	25	25	27	28
29	DOOR ALARM & CCTV SY	2000	891		20	45	45	49	29
30	CCTV MONITOR	2000	1,066		20	53	53	57	30
31	TEMPORARY TANK & ASP	2000	1,795		20	90	90	135	31
32	COMPRESSOR FOR WALK-	2000	1,270		20	64	64	85	32
33	DIESEL FUEL TANK	2000	1,000		20	50	50	100	33
34	TOTAL (lines 1 thru 33)		$ 2,400,436	$ 48,731		$ 95,974	$ 47,243	$ 1,685,832	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 2,400,436	$ 48,731		$ 95,974	$ 47,243	$ 1,685,832	1
2	SUPPLY PIPING	2000	2,067		20	103	103	180	2
3	600 GAL TANK ADD'N	2000	2,200		20	110	110	211	3
4	ELEVATOR REPAIRS	2001	5,924		20	296	296	296	4
5	KITCHEN/BATHROOM HRD	2001	661		20	28	28	28	5
6	BATHROOM HARDWARE	2001	665		20	28	28	28	6
7	ELEVATOR REPAIRS	2001	755		20	25	25	25	7
8	CCTV INSTALL & REPRS	2001	655		20	11	11	11	8
9	NURSES CALL SYSTM/RP	2001	506		20	19	19	19	9
10	CCTV INSTALL & REPRS	2001	1,358		20	51	51	51	10
11	WINDOWS	2001	730		20	25	25	25	11
12	1ST FLR NURSES STATN	2001	6,800		20	255	255	255	12
13	SERVC ST KEYED, KEYE	2001	1,315		20	17	17	17	13
14	ARMSTRONG TILE	2001	1,552		20	65	65	65	14
15	ELEVATOR REPAIRS	2001	5,000		20	167	167	167	15
16	ELEVATOR REPAIRS	2001	2,004		20	42	42	42	16
17	SRVC ON SPRNKLR VLV	2001	972		20	25	25	25	17
18	SRVC ON FRNT DR RELS	2001	548		20	5	5	5	18
19	SRVC ELCTRC TO ELEVT	2001	1,021		20	51	51	51	19
20	REPAIR SHORT CIRCUIT	2001	450		20	4	4	4	20
21	INSTALLED CCTV SYSTM	2001	1,325		20	11	11	11	21
22	INSTALL NURSES CALL	2001	2,435		20	10	10	10	22
23	ELEVATOR REPAIRS	2001	992		20	33	33	33	23
24	ELEVATOR REPAIRS	2001	1,467		20	24	24	24	24
25	ELEVATOR REPAIRS	2001	650		20	19	19	19	25
26	ELEVATOR REPAIRS	2001	2,820		20	12	12	12	26
27	ARCHITECT'S FEES	2001	1,458		20	73	73	73	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,446,766	$ 48,731		$ 97,483	$ 48,752	$ 1,687,519	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 2,446,766	$ 48,731		$ 97,483	$ 48,752	$ 1,687,519	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,446,766	$ 48,731		$ 97,483	$ 48,752	$ 1,687,519	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 2,446,766	$ 48,731		$ 97,483	$ 48,752	$ 1,687,519	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,446,766	$ 48,731		$ 97,483	$ 48,752	$ 1,687,519	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 2,446,766	$ 48,731		$ 97,483	$ 48,752	$ 1,687,519	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,446,766	$ 48,731		$ 97,483	$ 48,752	$ 1,687,519	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 2,446,766	$ 48,731		$ 97,483	$ 48,752	$ 1,687,519	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,446,766	$ 48,731		$ 97,483	$ 48,752	$ 1,687,519	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1982	1978	$ 2,059,134	$	26	$ 79,197	$ 79,197	$ 1,587,821	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocated from NuCare			1997	340	9	20	17	8	72	9
10	Allocated from NuCare			1998	298	8	20	15	7	52	10
11	Allocated from NuCare			1999	417	58	20	21	(37)	51	11
12	Allocated from NuCare			2000	507	13	20	25	(12)	37	12
13	Allocated from NuCare			2001	196	4	20	8	4	8	13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38	Various	1986	32,967		Various	1,741	1,741	27,438	38
39	Various	1987	4,735		19	249	249	3,502	39
40	Various	1988	8,738		19	377	377	5,278	40
41	Various	1989	11,001		20	550	550	6,875	41
42	Various	1990	1,919		20	96	96	1,104	42
43	Various	1991	5,128		20	256	256	2,688	43
44	Various	1992	4,600		20	230	230	2,070	44
45	Various	1993	16,600		20	830	830	7,055	45
46	Various	1993	1,016		20	51	51	433	46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,147,596	$ 92		$ 83,663	$ 83,547	$ 1,644,484	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 294,170	$ 2,462	$ 25,168	$ 22,706	10	$ 105,820	71
72	Current Year Purchases	13,320	555	626	71	10	626	72
73	Fully Depreciated Assets	395,450				10	9,570	73
74								74
75	TOTALS	$ 702,940	$ 3,017	$ 25,794	$ 22,777		$ 116,016	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Wagon	1991 FORD E150	1994	$ 2,200	$	$	$	5	$ 2,200	76
77										77
78										78
79										79
80	TOTALS			$ 2,200	$	$	$		$ 2,200	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,182,370	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 51,748	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 123,277	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 71,529	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,805,735	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Fire Alarm	$ 132,224	92
93			93
94			94
95		$ 132,224	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NuVision , LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1978		10/16/98	$ 765,702			3
4	Additions Monroe Associates				(765,702)			4
5	Allocation from NuCare				6,949			5
6								6
7	TOTAL				$ 6,949 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 10/16/98
Ending 12/31/2008

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$ 728,472
13.	/2003	$ 728,472
14.	/2004	$ 728,472

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 8,827 Description: Copy Rental $3515; Fax Machine $75; Allocation from Nucare $5237
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (171,160)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	863,034		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,686		6
7	Other Prepaid Expenses	3,637		7
8	Accounts Receivable (owners or related parties)	985,934		8
9	Other(specify): See supplemental schedule	40,606		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,749,737	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	304,574		15
16	Equipment, at Historical Cost	296,869		16
17	Accumulated Depreciation (book methods)	(270,626)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	173,276		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 504,093	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,253,830	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 19,770	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,004		28
29	Short-Term Notes Payable	500,000		29
30	Accrued Salaries Payable	138,016		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,277		31
32	Accrued Real Estate Taxes(Sch.IX-B)	77,384		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	8,465		35
	Other Current Liabilities(specify):			
36	See supplemental schedule	6,913		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 767,829	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 767,829	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,486,001	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,253,830	$	48

*(See instructions.)

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,158,655	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,158,655	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	327,346	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 327,346	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,486,001	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,295,670	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,295,670	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	179	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 179	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	1,133	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,133	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,296,982	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	806,670	31
32	Health Care	1,252,858	32
33	General Administration	907,913	33
	B. Capital Expense		
34	Ownership	919,746	34
	C. Ancillary Expense		
35	Special Cost Centers	7,989	35
36	Provider Participation Fee	74,460	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,969,636	40
41	**Income before Income Taxes (line 30 minus line 40)****	327,346	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 327,346	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Cash Basis **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,989	2,086	$ 71,093	$ 34.08	1
2	Assistant Director of Nursing	1,866	2,952	74,053	25.09	2
3	Registered Nurses	4,426	4,706	101,035	21.47	3
4	Licensed Practical Nurses	16,945	18,762	274,503	14.63	4
5	Nurse Aides & Orderlies	42,475	46,939	397,085	8.46	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,029	2,222	27,200	12.24	9
10	Activity Assistants	7,745	8,853	65,715	7.42	10
11	Social Service Workers					11
12	Dietician	1,909	2,086	38,560	18.49	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,551	15,791	122,244	7.74	15
16	Dishwashers					16
17	Maintenance Workers	2,891	3,077	56,060	18.22	17
18	Housekeepers	19,027	20,580	159,749	7.76	18
19	Laundry					19
20	Administrator	1,915	2,086	84,038	40.29	20
21	Assistant Administrator					21
22	Other Administrative	238	238	11,859	49.83	22
23	Office Manager					23
24	Clerical	3,009	3,317	51,087	15.40	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	10,725	11,021	134,235	12.18	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,452	2,539	28,865	11.37	31
32	Other Health Care(specify)					32
33	Other(specify)	212	212	7,989	37.68	33
34	TOTAL (lines 1 - 33)	134,404	147,467	$ 1,705,370 *	$ 11.56	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	145	$ 8,260	01-03	35
36	Medical Director	Monthly	9,000	09-03	36
37	Medical Records Consultant	Monthly	4,032	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,850	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	55	2,798	11-03	44
45	Social Service Consultant	82	4,244	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	282	$ 31,184		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rich Walworth	Administrator	0	$ 84,038
Kathy Brander	Dir Reg Mgmt		9,837
Ray Dolan	VP Risk Mgmt		2,021
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 95,896

B. Administrative - Other

Description	Amount
NuCare Services Corp.	$ 267,538
Carepath - Management Fees	24,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 291,538
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 12,313
Power Software	Computer	6,760
Health Data Systems	Computer	3,811
Horizon Healthcare	Computer	3,967
Personnel Planners	Unemployment Consult	1,770
Purchasing Plus	Purchasing	1,200
See Attached	Legal	18,563
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 48,384

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 21,993
Unemployment Compensation Insurance	9,311
FICA Taxes	124,524
Employee Health Insurance	29,523
Employee Meals	10,439
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	4,056
Ubion Health Insurance	47,940
Union Pension Benefits	11,944
Payroll Taxes Reimbursed	6,486
Other Employee Benefits	12,356
401K	1,785
TOTAL (agree to Schedule V, line 22, col.8)	$ 280,357

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Yellow Page Advertising	421
Dues & Subscriptions	7,085
Advertising & Promotion	1,959
Licenses & Inspections	2,749
Allocatin from NuCare	448
Allocation from Carepath	3,823
Less: Public Relations Expense	
Non-allowable advertising	(1,959)
Yellow page advertising	(421)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,105

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	560
Allocation from NuCare	875
Allocation from Carepath	14
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,449

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Repairs & Maintenance	1995	$ 4,185	3	$ 698	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
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17													
18													
19													
20	TOTALS		$ 4,185		$ 698	$	$	$	$	$	$	$	$

Facility Name & ID Number MONROE PAVILION HEALTH/T CTR # 0040071 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council on Long Term Care $7718**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **39** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? **X** YES ____ NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES **X** NO ____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Monroe Pavilion Health Center #0040071 - 7/1/94

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **74,460**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **10,439** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100% In 1**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees